



# UnitedHealthcare Community & State

Hoosier Care Connect Health Plan

CMS-1500 Claims and Dental Claims

Presented by Karen Cockerham, Provider Relations

United  
Healthcare®

# Agenda

- Claim Submission
  - CMS-1500
  - Dental
  - Vision
- Reconsiderations
  - Medical
  - Behavioral
  - Dental
  - March Vision
- Resources
- Questions and Answers



# Acronyms

- CMS – Centers for Medicare and Medicaid Services
- DOS – Date of Service
- EDI – Electronic Data Interchange
- FDA – Food and Drug Administration
- HCFA – Health Care Finance Administration
- INN – In-Network
- NDC – National Drug Code
- OON – Out-of-Network
- RFP-Request for Participation
- UHC- UnitedHealthcare



# Our Service Lines

- ❖ UnitedHealthcare
- ❖ Optum Behavioral Health
- ❖ March Vision
- ❖ UnitedHealthcare Dental



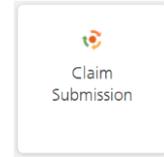


# Claim Submission

# How to file Medical/Behavioral CMS-1500 claims

- Submit claims using the CMS-1500 Claim Form (v 02/12)
- Standard Timely Filing for Par Providers - 90 calendar days from the date of service (DOS).
- Non-Contracted Providers Timely Filing – 180 calendar days from DOS.
- Newborn Claims Timely Filing – 180 calendar days from DOS.
- Secondary Claims Timely Filing - 90 calendar days from date of Primary EOB for INN Providers & 180 for OON providers from the Primary EOB date.

- For electronic submission:
- Payer ID 87726
- Claims Mailing Address:



UnitedHealthcare Community Plan  
P.O. BOX 5240  
Kingston, NY 12402

- Claim Submission Tool for Medical Professional claims (CMS 1500) on our UnitedHealthcare Provider Portal (formerly Link)
- Behavioral Health Professional claims (CMS-1500) on our Provider Express Portal
- Click claim entry



# How to file Dental claims

- HIPAA-Compliant 837D file

## HIPAA-Compliant 837D file

- The 837D is a HIPAA-compliant EDI transaction format for the submission of dental claims.
- This transaction set can be used to submit health care claim billing information, encounter information or both, from providers of health care services to payers via established claims clearinghouses.



# How to file Dental claims

## Paper Claims

- Refer to the [Quick Reference Guide](#) for addresses and phone number information.
- 100% of all clean paper claims will be paid or denied within 30 calendar days of receipt.
- 100% of all clean electronic claims will be paid or denied within 21 calendar days of receipt.

## Submitting Claims

To receive payment for services, practices must submit claims via paper or electronically.

Dentists must submit an American Dental (ADA) Dental Claim Form (2012 version or later).

Computer-generated forms are recommended.

Attach documentation and radiographs if applicable.

Attachments are required for pre-treatment estimates and for the submission of claims for complex clinical procedures.

Refer to the Exclusions, Limitations and Benefits section in the [Dental Services](#) manual to find the recommendations for dental services.



# How to file Dental claims

- Timely filing
  - All claims, including secondary claims, should be submitted within 90 calendar days from the date of service for participating providers or within 180 calendar days from the date of service for non-participating providers.

## Electronic Claims

- Electronic claims processing requires access to a computer and usually the use of practice management software.
- Electronically generated claims can be submitted through a clearinghouse or directly to our claims processing system via the internet.
- UnitedHealthcare Community Plan partners with electronic clearinghouses to support electronic claims submissions.
- If you wish to submit claims electronically, contact your clearinghouse to initiate this process.
- While the payer ID may vary for some plans, the Payer ID for **Community Plan members is GP133**.
- Please refer to the Important Addresses and Phone Numbers section for additional information as needed.
- Electronic submission is private as the information being encrypted.
- Call **1-877-897-4941** for more information regarding electronic claims submission.



## Tips for successful Dental claim resolution

- Do not let claim issues grow or go unresolved.
- Call Provider Services at 1-800-822-5353 if you cannot verify a claim is on file.
- Do not resubmit validated claims on file unless submitting a corrected claim with the required indicators.
- File adjustment requests and claims disputes within contractual time requirements.

- If you must exceed the maximum daily frequency for a procedure, submit the medical records justifying medical necessity. If you have questions, call Dental Provider Services.
- UnitedHealthcare Community Plan is the payer of last resort. This means you must bill and get an EOB from other insurance or source of health care coverage before billing UnitedHealthcare Community Plan.
- Secondary claims must be received within 365 days from the date of service, even if the primary carrier has not made payment.
- When submitting appeal or reconsiderations requests, provide the same information required for a clean claim. Explain the discrepancy, what should have been paid and why.



# How to file MarchVision Care claims

- Use our convenient online provider portal: [eyeSynergy.com](https://eyeSynergy.com)
- Submit claims electronically or via paper claim using the standard 1500 Claim Form
- Standard Timely Filing for Participating Providers - 90 calendar days from the date of service (DOS)
- Non-Contracted Providers Timely Filing 180 calendar days from DOS

- Online provider portal: [eyeSynergy.com](https://eyeSynergy.com)

The logo for eyeSynergy, with "eye" in orange and "Synergy" in blue.

- For electronic submission:  
**Payer ID 52461**

- **Claims Mailing Address:**



**MARCH® Vision Care**  
**6601 Center Drive West, Suite 200**  
**Los Angeles, CA 90045**





# Reconsiderations

# MEDICAL

## When Should You Submit a Claims Reconsideration?

- You should submit a claims reconsideration request through the Claims tool when you believe a claim was processed incorrectly. Situations for reprocessing include, but are not limited to:
  - Paid amount is different than what provider expected
  - Claim was filed in a timely manner, when provider has proof
  - Claim was denied for no authorization, when provider has an authorization number
  - Difference in Coordination of Benefits (COB) information



# How Do I Submit a Medical Claims Reconsideration Within the Tool?

Click **Create Claim Reconsideration** to start your reconsideration request or submit a corrected claim.

Providers have 90 calendar days from the original EOB date to submit a Claim Reconsideration.

Need a paper form because you are unable to submit your reconsideration online? Use our Single Paper Claim Reconsideration Request Form found at the link below and mail to the claims mailing address:

<https://www.uhcprovider.com/content/dam/provider/docs/public/claims/UHC-Single-Paper-Claim-Reconsideration-Form.pdf>



# Example of How to Submit Corrected Claim

The screenshot displays the 'Act on Claim' interface. At the top left, there is a pencil icon and the text 'Act on Claim'. At the top right, there is an upward-pointing arrow icon. The main content area is divided into four sections, each with a corresponding action button on the right:

- Corrected Claim**: A red arrow points from this section to a blue button labeled 'Submit Corrected Claim', which is highlighted with a yellow border.
- Claim Reconsideration**: Includes a link '+ When should you submit a claim reconsideration request?' and a blue button labeled 'Create Claim Reconsideration'.
- File Appeal/Dispute**: Includes a link '+ When should you submit an Appeal/Dispute?' and a blue button labeled 'File Appeal/Dispute'.
- Add Attachment for Pending Claim**: Includes the text 'Please provide requested documentation to complete the adjudication of this claim.' and a grey button labeled 'Action Required'. A note to the right of the button states 'This is not available for this claim, at this time.'



# Corrected Claims - Claims

 **Request Information and Comments** 

### Request Information

All Fields are Required

Amount Requested

 I don't know

Request Reason

▼

### Request Comments

Please include what you are expecting from UnitedHealthcare to close this in your practice management system in the amount requested field, and include any additional comments you would like in the comment field.

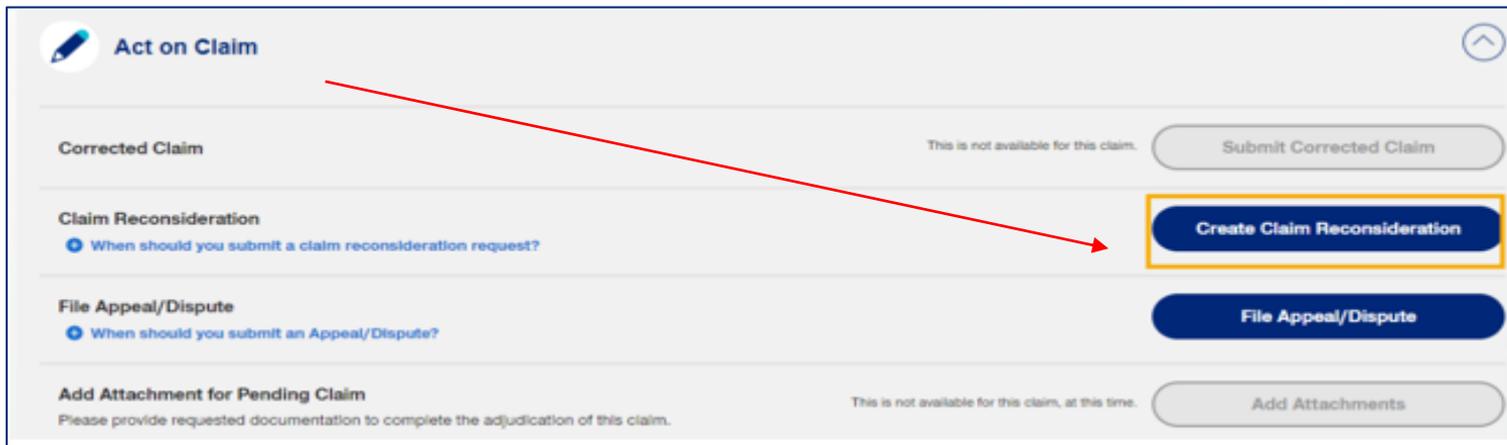
New Comment

*Comments are required*

- In **Amount Requested**, enter the total amount you expect for the claim, including any previous payments.
- Select Resubmission of a Corrected Claim as the Request Reason from the pulldown menu.
- Help us understand the situation by adding a New Comment.



# Example of How to Create a Reconsideration



The screenshot displays the 'Act on Claim' interface. At the top left, there is a pencil icon and the text 'Act on Claim'. A red arrow points from the top left towards the 'Create Claim Reconsideration' button. The interface is divided into four sections, each with a title and a button:

- Corrected Claim**: This is not available for this claim. [Submit Corrected Claim](#)
- Claim Reconsideration**: [When should you submit a claim reconsideration request?](#) [Create Claim Reconsideration](#)
- File Appeal/Dispute**: [When should you submit an Appeal/Dispute?](#) [File Appeal/Dispute](#)
- Add Attachment for Pending Claim**: Please provide requested documentation to complete the adjudication of this claim. This is not available for this claim, at this time. [Add Attachments](#)



# MEDICAL

- Scroll down to review the details
- Enter your contact information in the Submitter's Contact Information section.
- Once Submitted, document the ticket number received

Current Claim Status: ▲ Denied • First Date of Service: 08/08/2020 • Total Billed: \$1,234.56

[Contact Information](#) | [Request Information & Comments](#) | [Attachments](#) [View Patients Eligibility & Benefits](#)

### Create a Reconsideration

This form is to be completed by physicians, hospitals or other health care professionals to request a claim reconsideration for members enrolled in benefit plans administered by UnitedHealthcare. **A separate request must be filled out for each claim reconsideration. Don't use this form for appeals or disputes. Continue to use your standard appeals process for formal appeals and disputes.**

 **Contact Information** ⤴

#### Provider Information

Billing Provider <b>Medical Center</b>	Tax ID Number 123456789
Servicing Provider <b>Jamie Doctor</b>	

#### Submitter's Contact Information

All Fields are Required

First Name <input type="text" value="Taylor"/>	Last Name <input type="text" value="Demo"/>	
Phone Number <input type="text" value="(555) 955-4555"/>	Email Address <input type="text" value="email@sample.com"/>	
<small>(###) ###-####</small>		
Street Address <input type="text" value="123 Demo St"/>		
City <input type="text" value="Great City"/>	State <input type="text" value="VA"/>	ZIP Code <input type="text" value="23456"/>



# BEHAVIORAL

## How do I Submit a Claims Reconsideration?

Securely login to Provider Express

- Claim Inquiry
- Search for claim
- Click Enter under claim adjustment

*Providers have 90 calendar days from the original EOB date to submit a Claim Reconsideration.*

Home Eligibility & Benefits Auth Request Auth Inquiry Claim Inquiry **Claim Inquiry EPR** ALERT Provider Reports My Provider Express My Practice Info Message Center Contact Us

Claim Inquiry\* - indicates required field(s)

[Click here to register for or view Electronic Payments and Statements](#) [Can't find claim status online?](#)

My Patients | Member ID Search | Name/DOB Search

Please complete the form below and click "Search"  
\* - indicates a required field

Member ID -

Group #

First Name -

Optional - Dates of Service (defaults to 180 days before today's date)

Month and Year  
 Date Range (180 day limit)  
 Previous 12 Months  
 Previous 24 Months

Provider Express recommends using the minimum search criteria of Member ID and First Name only. Do not enter a group number unless the system prompts you via a specific message.

Search

### Claim Detail

Date(s) of Service:	11/11/2015	Date Paid:	11/14/2015				
Clinician Name:	Provider, John Q.	Check #:	0				
Authorization #:							
Payee Name:	John Q Provider	Claim #:	X0987654321				
Address:	123 Main Street Anywhere USA 55555	Place Of Service:	OFFICE				
		Service Code:	90834HJ				
Claimed Amount:	Contract Rate:	Deductible Amount:	PT Responsibility:	Disallowed Amount:	Paid Amount:	Claim Status:	Claim Adjustment:
\$80.00	\$80.00	\$0.00	\$0.00	\$0.00	\$60.00	Finalized	Enter

Explanation:

Optum follows the prompt payment regulations applicable to each state and payments on finalized claims will be paid within these timeframes. Please be aware that some customers have asked to have payments made in batches, releasing payment for a number of clinician claims at specified intervals rather than as each claim is received and processed. The claim status detail will be updated with Paid Date, Check Number and other claim details once a payment has been released. If you have additional questions about this claim, please contact Optum at the toll-free number located on the member's ID card.

Previous Page Summary Page New Inquiry



# BEHAVIORAL

- Select a reason from the dropdown
- Select Review
- Review details and add necessary comments on next screen
- Select Submit
- Once Submitted, document the Confirmation Number and Issue ID

**Claim Adjustment - Entry**

After a claim has been processed, you may make a Claim Adjustment request. If you believe that a claim was processed incorrectly, please select a Reason from the list below. In addition, please include any information that should be evaluated in the claim adjudication process.

**Member Name** MEMBER NAME **Member Id** XXXXX0000-00  
**Clinician Name** Provider, John Q.

Date(s) of Service	Date Paid	Claimed Amount	Copay Amount	Disallowed Amount	Paid Amount
11/11/2015	11/14/2015	\$60.00	\$60.00		\$0.00

**Reason**

**Comment** COB Adjustment  
Claim Paid to Incorrect Provider  
Change in Patient Eligibility  
Incorrect Member Liability which was met on 10/31/2015. Please reprocess.

255 characters left

---

**Member Name** MEMBER NAME **Member Id** XXXXX0000-00  
**Clinician Name** Provider, John Q.

Date(s) of Service	Date Paid	Claimed Amount	Copay Amount
11/11/2015	11/14/2015	\$60.00	\$60.00

**Confirmation Number:** 500000005  
**Issue Id:** C21911807314774  
**Reason:** Incorrect Member Liability

**Comments:**  
Claim processed against member deductible, which was met on 10/31/2015. Please reprocess and pay.



# MEDICAL & BEHAVIORAL

What if I don't agree  
with the outcome of  
my Claim  
Reconsideration?

- If you disagree with the outcome of your Claim Reconsideration, please take the issue to your Indiana Medical or Behavioral Advocate Team.

## Medical

**Northern Indiana** – Lori Reeder – [lreeder@uhc.com](mailto:lreeder@uhc.com)

**Central Indiana** - Karen Cockerham [\\_karen.cockerham@uhc.com](mailto:karen.cockerham@uhc.com)

**Southern Indiana** – Kim Berry – [kim\\_berry@uhc.com](mailto:kim_berry@uhc.com)

## Behavioral Health

Belen Stewart – [belen.stewart@optum.com](mailto:belen.stewart@optum.com)



# MEDICAL & BEHAVIORAL

## What is the next step in the Reconsideration Process?

- If you still disagree with the outcome of your claim after the Advocate team has escalated, your next step is to file a formal appeal.
- Must be submitted within 60 calendar days from the failed reconsideration
  - Mail to:
    - UnitedHealthcare Community Plan of Indiana,  
Attn: Appeals and Grievances Unit  
PO Box 31364  
Salt Lake City, UT 84131-0364
    - Submit within Claims on our UnitedHealthcare Provider Portal



# MEDICAL & BEHAVIORAL

What if I still  
disagree?

- If you still disagree with the outcome of your formal dispute, you may file a Formal Provider Grievance.
- Must be submitted within 120 calendar days from the failed Dispute (Must include additional or new information).
- Mail to:
  - UnitedHealthcare Community Plan of Indiana  
Attn: Appeals and Grievances Unit  
Box 31364  
Salt Lake City, UT 84131-0364
- Submit within Claims on our UnitedHealthcare Provider Portal



# March Vision

## How do I Submit an Informal Dispute?

Providers have 60 calendar days from the original EOB date to submit a Claim Reconsideration.



### Provider Dispute Resolution Process

1. Providers have sixty (60) calendar days to file an informal dispute. This must be in writing (paper, portal, email, etc.), not taken over the phone.
2. We have thirty (30) calendar days to respond or request additional information.
3. If the dispute is not resolved to your satisfaction, you will have sixty (60) calendar days after the end of the thirty (30) calendar day period to submit a formal appeal. The appeal must be in writing.
4. The appeal review is conducted by a panel of one (1) or more individuals selected by the MCO.
5. The panel's written determination must be issued within forty-five (45) calendar days. Failure to respond within forty-five (45) calendar days shall have the effect of an approval.

Please submit your request by mail to:

MARCH® Vision Care  
Attention: Claims Appeals  
6601 Center Drive West, Suite 200  
Los Angeles, CA 90045

You can also use our online form to submit electronically from the following link:

<https://forms.marchvisioncare.com/Forms/PDR>



# How to file Dental Corrected Claims

- **Corrected claim process**

Providers who receive a claim denial and need to submit a corrected claim should submit a corrected claim and appropriate documentation, if necessary, to:

- **Corrected Claims Address**

P.O. Box 481

Milwaukee, WI 53201

- You can submit a request for an additional claim review, if a claim was denied due to missing information, missing tooth number/ surface on the original submission or you have additional information you feel may change the claim payment decision.
- The determination of a corrected claim request will be provided a remittance statement within 30 days of receipt.



# How do I dispute how a dental claim was processed/denied?

## Appealing a denied claim payment

- Providers have the right to appeal a claim payment that is fully or partially denied. UnitedHealthcare will follow state and Federal guidelines in the management of the appeals process, including 405 Indiana Administrative Code (IAC) 1-1.6.
- Providers may submit an Informal Objection within 60 days of the adverse claim determination ("claim denial"). This Informal Objection must be submitted in writing at the address below. The Informal Objection will be reviewed and resolved within 30 days.
- If providers are not satisfied with the resolution to the Informal Objection, providers may submit a Formal Appeal in writing within 60 days of the Informal Objection to the same address below. The Formal Appeal will be reviewed and resolved within 30 days.





# Resources

# Additional Claims Trainings on UHCprovider.com

[Referrals: Interactive User Guide](#)

[Track-It Self-Paced User Guide](#)



# Administrative Provider Resources – Medical and Vision Claims



- Education resources for submitting claims are available on our provider website.
- Claim system configuration follows Federal and Indiana Medicaid claims billing guidelines.
- Accept paper or electronic claim submissions.
  - Link to file **professional** claims with United Healthcare [UHCprovider.com/claims](https://UHCprovider.com/claims)



# Medical Claims and Eligibility

- Check claim status
- Check member eligibility status
- Start a claim reconsideration or appeal once claim ID is pulled up
- Obtain electronic image of a member's Hoosier Care Connect Insurance Card

## Hello, Taylor

Before you get started, make sure your [payer information](#) and [provider information](#) in the top right corner of the page are correct. Try out our shortcuts to eligibility and claims information below for quick links to common tasks.

### Verify Eligibility & Benefits

[View Recent Search Results](#)

Select Your Eligibility Search Criteria\* \*Required Fields

Member ID & Date of Birth

Member ID\*  Date of Birth\*

MM/DD/YYYY

[Search for Multiple Members](#)

Leaving the dates blank will default to using today's date and will return current, past and future policies. You may also enter a date range up to 6 years in the past and 12 months in the future.

First Service Date  - Last Service Date

MM/DD/YYYY MM/DD/YYYY

[Verify Eligibility](#)

### Look Up a Claim or Ticket

[View Flagged Claims in Trackit](#)

Select Your Claim or Ticket Search Criteria\* \*Required Fields

Member ID & Date of Birth

Search By:  TIN **123456789** [Edit](#)  Provider [Infusion Services](#) [Edit](#)

Member ID\*  Date of Birth\*

MM/DD/YYYY

Select Range:  Custom Date  Predefined Date

You may search for claims up to 18 months in the past.

First Service Date\*  - Last Service Date\*

MM/DD/YYYY MM/DD/YYYY

[Submit Search](#)

[Feedback](#)

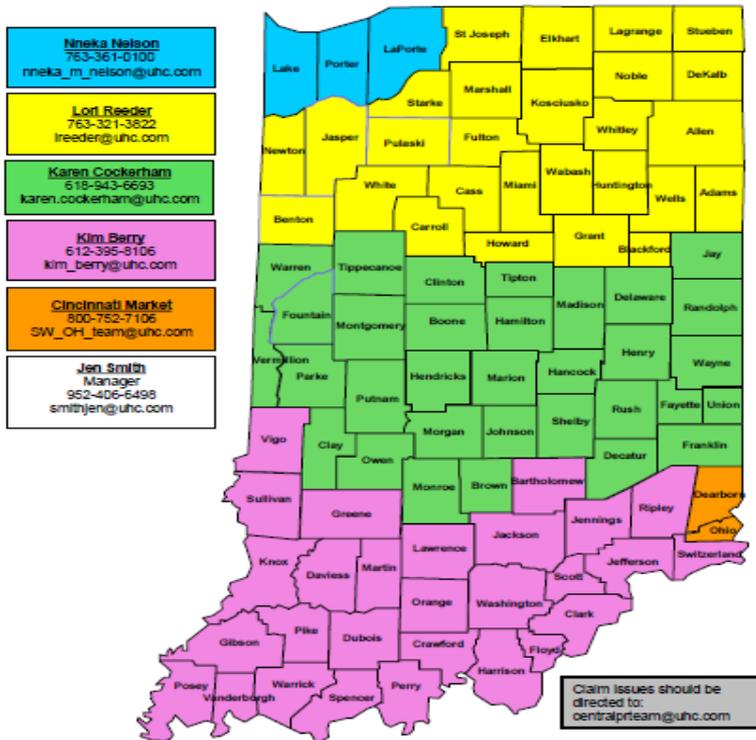




# **Provider Advocate Teams**

# Indiana Provider Advocate Account Manager Territory Map

UnitedHealthcare  
Indiana Provider Advocate Account Manager Territory Map





# Your Optum Behavioral Health ABA Advocate

**Nacole Thompson**  
**Provider Advocate**  
ABA Therapy- all counties  
952-406-6449  
Nacole.Thompson@optum.com



# Your Optum Behavioral Health Advocate Team

**Belen Stewart**  
Provider Advocate  
Behavioral Health  
612-632-5962  
Belen.Stewart@optum.com

**David Hoover**  
Senior Provider Advocate  
Behavioral Health  
763-330-7588  
David\_Hoover@optum.com



# Questions and Answers

Thanks for Attending Today's Session



# Provider Reference Appendix



## Provider Service Line Website Links

- United Health Community Plan (Medical): [www.uhcprovider.com/INcommunityplan](http://www.uhcprovider.com/INcommunityplan)
- UHC Dental: [www.uhcdentalproviders.com](http://www.uhcdentalproviders.com)
- MarchVision: [www.marchvisioncare.com](http://www.marchvisioncare.com)
- Optum Behavioral Health: [www.providerexpress.com](http://www.providerexpress.com)

